WASHINGTON OZAUKEE COUNTY PUBLIC HEALTH DEPARTMENT

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121 West Main St., Port Washington, WI 53074 *333 E. Washington St., West Bend, WI 53095*

OZAUKEE COUNTY

VACCINE ADMINISTRATION RECORD Adapted from DHFS PH 4702 (7/06)

Information collected on this form will be used to document authorization for receipt of vaccine(s). Information may be shared through the Wisconsin Immunization Registry (WIR) with other health care providers directly involved with the patient to assure completion of the vaccine schedule. Information collected on this form is voluntary and the Social Security Number will be used by parent or guardian to access the online Wisconsin Immunization Registry.

Patient's Name (Last, First, Middle Initial)		Date of Birth (mm/dd/yyyy) _____ Age: _____	
Address	P. O. Box	Patient Birth State/Country	
City	County	State	Zip Code
Email address (If applicable)	Home Telephone Number ( )	Work Telephone Number ( )	Extension
Social Security Number	Mother's Maiden Name (Last, First, Middle Initial)	Gender ☐Male ☐Female	
Race (Check one) ☐African American ☐ Asian ☐ Caucasian ☐Native American ☐ Other		Ethnicity (Check one) ☐ Hispanic ☐Non-Hispanic	

Eligibility Status (Check all that apply) This section must be completed. ☐ **Native American** ☐**Medicaid Eligible** ☐**Badger Care** ☐**No Health Insurance** ☐ **Insured, Vaccines Covered** ☐ **Insured, Vaccines Not Covered**

Name of Physician	Name of Insurance Provider	Name of School or Day Care (If applicable)
Name of Parent or Guardian Responsible for Patient (Last, First, Middle Initial)		Relationship to Patient
Okay to share immunization data with WIR? ☐ Yes ☐ No	Is reminder or recall contact allowed? ☐Yes ☐No	Would you like reminder/recall sent to you? ☐Yes ☐No

I have been given a copy and have read, or have had explained to me, information about the disease(s) and vaccine(s) to be received. I have had a chance to ask questions that were answered to my satisfaction. I understand the benefits and risks of the vaccine(s) requested and ask that the vaccine(s) be given to me or to the person named above for whom I am authorized to make this request.

Wisconsin Medicaid restricts billing recipients for any covered service(s). I understand that if I am a Medicaid/BadgerCare recipient I cannot be charged an administration fee or asked for any type of donation for the administration of any vaccine that is being provided.

SIGNATURE - Person to receive vaccine or person authorized to sign on the patient's behalf. **X**	Date Signed